

Retiree Life Insurance Request to Cancel Coverage Form

Name: _____ (Please print)

Address: _____

City, State, Zip: _____

Last 4 digits of your Social Security Number: _____

Please initial each of the following:

_____ I acknowledge that my election to cancel coverage is irrevocable.

_____ I request to cancel my \$50,000 Retiree Life Insurance Policy.

I understand that my decision to cancel this insurance coverage is irrevocable. Coverage cannot be reinstated at a later date. If you are attempting to place another policy, do not discontinue coverage until your replacement coverage is active.

Coverage will be discontinued on the first day of the month following receipt of your properly completed Request to Cancel Coverage Form. If you have questions on the completion of this form, please call 1-877-608-0044.

Signature

Date